POS Facilitated Enrollment: Pharmacy Q&As

1. The Q&A indicates that the response will include a copay but does not address whether the remainder of the claim will be paid. How will claims be paid?
Most pharmacies' claims will process as paid claims whether the pharmacies are in or out of a contracted WellPoint network - but on some occasions when the pharmacy is out-of-network, special instructions will need to be sent to the pharmacy to establish the mechanism for payment. Contracted pharmacies are paid in-network rates; out-of-network pharmacies are paid usual and customary rates.

2. How will stores be notified of the 'proper' payer to bill?
All claims generated by the POS process will be billed in accordance with the same WellPoint (Anthem) payer sheet that has been distributed by WellPoint to its network pharmacies. Additional guidance may be provided by WellPoint, as needed. Pharmacies who want information on how to process a POS facilitated enrollment claim should contact the WellPoint pharmacy help desk at 800-662-0210, as indicated on the payer sheet. Please note this area will only be able to answer questions from pharmacies with processing questions. Any questions pertaining to policy should be referred to CMS.

3. Does voluntary enrollment into a plan for a full benefit dual eligible (FBDE) missed in auto-enrollment disqualify him/her for the POS facilitated enrollment process?

A: A FBDE who has voluntarily enrolled in a plan effective the 1st of the following month is eligible for the POS facilitated enrollment process in the current month. The beneficiary can obtain drug coverage in the period between his enrollment submission and the date of effective coverage under this special process. The FBDE can access his/her drug coverage by presenting him/herself at the pharmacy point-of-sale with the appropriate proof of Medicare and Medicaid eligibility. Once full dual eligibility status has been verified, the pharmacist will be able to bill the POS Contractor until the effective date of coverage for the selected plan begins. Once coverage under the selected plan is effective, drug coverage will not be available under POS and the pharmacist may have to perform an E1 query to identify the new plan to bill.

Example: A beneficiary with dual eligible status was missed in the January auto-enrollment. Having realized that he was missed in the auto-enrollment, the beneficiary voluntarily submits enrollment to a CIGNA prescription drug plan with a February 1, 2006 effective date.
Questions:
1) Will the beneficiary be eligible for drug coverage under the POS process for the remainder of January? **Yes**
2) If the beneficiary enters the POS process in January, will this disenroll him from the CIGNA plan on February 1, 2006? **No. On February 1, 2006, his drug coverage with CIGNA will become effective and his drug coverage under POS will end.**

4. What is the maximum length of fill payable by WellPoint?
WellPoint will allow up to a 30 day fill in order to balance both risk to pharmacies and the times an individual needs to return to the pharmacy to get a refill. Pharmacies may elect to fill less than a 30 days supply.

5. What happens if after the first 30 days of the first POS transaction, the E1 transaction continues to return no drug coverage and the individual has been verified to be a dual?

A: If after 30 days the E1 transaction continues to return no coverage, and the pharmacy has re-verified the dual eligibility of the individual, then the POS payer will allow another fill up to 30 days.

6. Can pharmacies continue to submit claims through POS indefinitely?
A: Wellpoint limits fills to 30 days, but allows multiple refills if the dual has not been enrolled in a plan by the end of the fill. Once Wellpoint is informed that the beneficiary is eligible to be enrolled, it will terminate the POS record and enroll the beneficiary in Unicare. However, Wellpoint is informed that the beneficiary is not eligible for the POS process, it will terminate the POS record and no further fills will be available. We expect that true unassigned duals will be enrolled in a Unicare plan before multiple fills will be required. CMS and Wellpoint remain in close communication and will adjust process parameters as required.

7. Will WellPoint be able to block any future claims for any individual who has been previously deemed ineligible so the need for future reversals will be prevented?
In the interim period between the initial claim submission and when the Enrollment Contractor has validated eligibility, the individual will be identified by his/her HICN. If the Enrollment Contractor verifies that the individual is ineligible for facilitated enrollment, WellPoint will immediately flag the HICN to prevent the same individual from entering the POS process again.

8. Do pharmacies have to submit claims to Medicaid and receive a denial before proceeding with the POS facilitated enrollment process?
No. Pharmacies need only confirm reasonable evidence of Medicaid eligibility as described in Question 6.

9. How can pharmacies verify Medicaid eligibility to minimize the pharmacy's risk?
In addition to existing state resources, such as IVR systems, pharmacies can use the following as verification of Medicaid eligibility:

- Medicaid ID card
- Recent history of Medicaid billing in the pharmacy patient profile
- Copy of current Medicaid award letter

10. How can pharmacies verify Medicare eligibility?

The pharmacist can check for either Part D enrollment **or** eligibility for Medicare Parts A & B by submitting an E1 query to the TrOOP facilitator. Other (offline) ways to check for A/B Medicare eligibility are:

- Request to see a Medicare card; or
- Request to see a Medicare Summary Notice (MSN); or
- Call the dedicated Medicare pharmacy eligibility line (1-866-835-7595) available Mon.-Fri. 8 AM-8PM EST; or
- Call 1-800-MEDICARE (available 24/7)

Please note that the dedicated pharmacy eligibility line is set up to address questions concerning beneficiary Medicare eligibility or enrollment in Part D plans, not other pharmacy issues. Questions concerning the E1 process should be directed to the TrOOP Facilitation Help Desk at NDCHealth at 1-800-388-2316.

11. Will pharmacies have to re-bill from WellPoint to UNICARE once the individual has been enrolled in the appropriate regional UNICARE plan?
No. However, after enrollment, the next claim will need to be submitted to UNICARE.

12. In the event that that a pharmacy submits a claim in error to WellPoint, how will WellPoint recover the amount paid in error - how will the pharmacy be contacted?

Pharmacies will be notified of all claims that need to be reversed by WellPoint. National or large chain pharmacies are encouraged to establish a single point of contact for handling POS claims to ensure a smooth claims processing/billing process between the pharmacy and WellPoint. WellPoint will contact the pharmacy by telephone or fax (as arranged) and one of the following situations will occur:

- Individual is Medicaid-eligible only: WellPoint contacts the pharmacy to reverse the claim to the pharmacy and the pharmacy bills the appropriate State Agency. We expect this to be a rare outcome given that the pharmacist will have verified Medicare, and thus, dual eligibility using one of the several methods available.

- Individual is a dual-eligible but already enrolled in another plan: WellPoint contacts the pharmacy to reverse the claim and informs the pharmacy of the appropriate plan to bill (see Question 12, below). The pharmacy bills the appropriate plan.

- Individual is Medicare-eligible only: The Enrollment Contractor will notify the individual that they are not eligible for facilitated enrollment, but are eligible for Part D and must enroll in a Part D plan to obtain drug coverage. WellPoint contacts the pharmacy to reverse the claim, but will not know if or where they may have enrolled. The pharmacy can submit an E1 query to identify the payer for future claims, but will have to collect from the individual on the current claim. We expect this to be a rare outcome given that the pharmacist will have verified Medicaid, and thus, dual eligibility using one of the several methods available.

13. Will WellPoint consider a payer-to-payer reconciliation process for ineligible claims instead of a claim reversal to the pharmacy?
If CMS and the industry develop a plan-to-plan solution for claim reconciliation, WellPoint will participate in this process.

14. Will WellPoint consider billing ineligible individuals for ineligible claims instead of a claim reversal to the pharmacy?
WellPoint, like the pharmacies, understandably wants to avoid billing ineligible individuals because these are likely to be low-income individuals. We expect that proper verification of Medicare/Medicaid eligibility by the pharmacist will greatly reduce the likelihood that ineligibles will enter the POS process.

15. In the event an enrollment is denied due to previous enrollment in another Part D plan, will it be possible for WellPoint to know who the other payer is when contacting the pharmacy about a reversal?
In many cases, yes. In the situation in which the individual is actually already enrolled in another Part D plan, WellPoint will contact the pharmacy to reverse the claim and make best efforts to inform the pharmacy of the appropriate plan to bill. The Enrollment Contractor will provide WellPoint with the CMS contract number for any such Part D plans, and WellPoint will use a crosswalk table provided by CMS to provide "4Rx" data on these plans to the pharmacy to facilitate re-billing. CMS has already provided WellPoint with a table for all of the plans eligible for the dual eligible auto-enrollees, and will provide data on additional plans as they become available through the CMS enrollment process.

16. Could WellPoint establish a deadline for reversals, after which WellPoint would assume responsibility for collection from any ineligible individual?
WellPoint will use the industry standard claim reversal window of 180 days, as indicated on the payer sheet.

17. If a member turns out to be eligible for the $2/$5 cost sharing subsidy level instead of the $1/$3 level, will WellPoint adjust future claims to recoup the balance owed instead of requiring reversal and rebilling of claims through the pharmacy?
WellPoint will not reverse claims just to adjust the copay level. Once the person is enrolled into the appropriate UNICARE plan, future claims will be processed at the higher appropriate copays.

18. Under the POS process, there is an open formulary. What happens if Z-Tech verifies that the individual has already been auto-enrolled and a POS claim which contains a drug not covered by the plan (who received the auto-enrollment) has been submitted to WellPoint on behalf of the individual?
All Part D plans have a first fill transition policy, so we do not believe claims for non-formulary drugs will present a problem between different Part D plans.

19. Which beneficiary identifiers will pharmacies have to submit to WellPoint in the billing transaction?

Pharmacies will have to submit the beneficiary's Medicare ID number (known as the HICN), as well as the Medicaid ID number. Both numbers are critical to rapid verification of dual eligibility and should be available from all the valid sources of Medicaid or Medicare eligibility verification, as noted in Questions 6 and 7.

If pharmacy systems do not currently support the entry of more than one ID number into the B1 record, we ask that efforts be made as soon as possible to do so since this will allow the eligibility verification process to be more fully automated and expedited. In the meantime, if a pharmacy's data entry systems do not currently support the Patient ID field [332-CY or 331-CX], we ask that the pharmacy support one of the following two workarounds until they can:

1. Have the pharmacist enter the Medicaid ID in the Group ID field [301-C1] of the insurance segment AND bill a separate payer account: BIN: 610575; PCN: CMSDUAL**02**; or

2. Have the pharmacist enter the Medicaid ID in the Group ID field [301-C1] of the insurance segment AND include the Patient ID Qualifier field [331-CX] AND program the pharmacy system to map the Group ID field to the Patient ID field in the creation of the B1 transaction.